

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155149</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/22/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HARCOURT TERRACE NURSING AND REHABILITATION</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>8181 HARCOURT RD INDIANAPOLIS, IN 46260</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code and Environmental Preoccupancy Survey for the renovation of the memory care wing was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/22/12</p> <p>Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code and Environmental Preoccupancy Survey, Harcourt Terrace Rehabilitation and Health Care Center was found in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities for the renovation of the memory care wing.</p> <p>This one story facility was determined to be of Type III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 116 and had a census of 78 at the time of this visit.</p>			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155149</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/22/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HARCOURT TERRACE NURSING AND REHABILITATION</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>8181 HARCOURT RD</b> <b>INDIANAPOLIS, IN 46260</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page 1  Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/24/12.			K 000			